

CDC REYE SYNDROME CASE INVESTIGATION REPORT

ID No. (1-4)
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Please write in where necessary, and check boxes where applicable (disregard numbers in parentheses).

1. Name of Reporting Individual		2. First 3 letters of Patient's last name (5-7)	
Address Street		3. State	
City State Zip Code		4. County	
Telephone No. (Area Code)		5. Age in years: (if under 3 yrs old) months (13-14) (15-16)	
Name of Hospital With Which Affiliated		6. Patient's Sex: (17) <input type="checkbox"/> 1. Male <input type="checkbox"/> 2. Female	
Name of City in Which Hospital is Located		7. Patient's Race: (18) <input type="checkbox"/> 1. White <input type="checkbox"/> 3. Asian or Pacific Islander <input type="checkbox"/> 2. Black <input type="checkbox"/> 4. American Indian or Alaskan Native	
		8. Patient's Ethnicity: (19) <input type="checkbox"/> 1. Of Hispanic Origin <input type="checkbox"/> 2. Not of Hispanic Origin <input type="checkbox"/> 3. Not Specified	

9. Was patient hospitalized? (20) ☐ 1 Yes ☐ 0 No ☐ 9 Unknown

IF PATIENT HOSPITALIZED, REPORT THE FOLLOWING FOR EACH HOSPITAL IN WHICH PATIENT WAS HOSPITALIZED:

Name and City of 1st hospital	Name and City of 2nd hospital
Date of 1st hospitalization Mo. Day Yr. (21-26)	Date of 2nd hospitalization Mo. Day Yr. (33-38)
Date of discharge from 1st hospital, or death (27-32)	Date of discharge from 2nd hospital, or death (39-44)

10. Date of onset of Reye Syndrome (onset of severe vomiting or mental status change, whichever appeared first). Mo. Day Yr. (45-50)

11. During the 3 weeks before onset of Reye Syndrome was there an antecedent illness? (51) ☐ 1 Yes ☐ 0 No ☐ 9 Unknown

If yes, date of onset of antecedent illness Mo. Day Yr. (52-57)

12. If there was an antecedent illness, was there:

	Yes	No	Unknown	
Diarrhea as part of the antecedent illness?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	(58)
Respiratory symptoms as part of the antecedent illness?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	(59)
Fever as part of the antecedent illness?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	(60)
Chickenpox as the antecedent illness?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	(61)
Other rash as part of the antecedent illness?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	(62)

13. A. Was there vomiting at any time? (63) ☐ 1 Yes ☐ 0 No ☐ 9 Unknown

B. If there was vomiting at any time, was the vomiting? (check only one) (64) Part of the antecedent illness ☐ 1 or part of both antecedent and Reye Syndrome ☐ 3 Part of the Reye Syndrome ☐ 2 Unknown ☐ 9

14. A. Check the appropriate box to indicate the best description of the patient's condition at admission to the hospital where the major part of therapy (or at diagnosis, if not hospitalized) was performed.

B. Check the best description of the patient's condition during the most severe phase of illness.

	A. Patient's Condition at Admission (Check Only One) (65)	B. Patient's Condition During Most Severe Phase of Illness (Check Only One) (66)
Alert wakefulness	0 <input type="checkbox"/>	<input type="checkbox"/>
Difficult to arouse, lethargic, sleepy	1 <input type="checkbox"/>	<input type="checkbox"/>
Delirious, combative, purposeful or semi-purposeful motor responses	2 <input type="checkbox"/>	<input type="checkbox"/>
Unarousable, predominantly flexor motor responses, decorticate	3 <input type="checkbox"/>	<input type="checkbox"/>
Unarousable, predominantly extensor motor responses, decerebrate	4 <input type="checkbox"/>	<input type="checkbox"/>
Unarousable, flaccid paralysis, areflexia pupils unresponsive	5 <input type="checkbox"/>	<input type="checkbox"/>
Courarized or equivalent, therefore could not classify	6 <input type="checkbox"/>	<input type="checkbox"/>
Condition unknown	9 <input type="checkbox"/>	<input type="checkbox"/>

15. Was patient vaccinated during month preceding onset of Reye Syndrome? (67)

☐ 1 Yes ☐ 0 No ☐ 9 Unknown

IF YES, SPECIFY VACCINE AND DATE RECEIVED

Vaccine	Date Received Mo. Day Yr. (68-73)

16. Did the patient ever have a previous case of physician-diagnosed Reye Syndrome? (86)

☐ 1 Yes ☐ 0 No ☐ 9 Unknown

17. Has Reye Syndrome ever been diagnosed in a sibling or blood relative? (87)

☐ 1 Yes ☐ 0 No ☐ 9 Unknown

CDC 55.8 (Formerly 4.571K)

REV. 9-91

The Centers for Disease Control (CDC), an agency of the Department of Health and Human Services, is authorized to collect this information, including the Social Security number (if applicable), under provisions of the Public Health Service Act, Section 301 (42 U.S.C. 241). Supplying the information is voluntary and there is no penalty for not providing it. The data will be used to increase understanding of disease patterns, develop prevention and control programs, and communicate new knowledge to the health community. Data will become part of CDC Privacy Act system 09-20-0136, "Epidemiologic Studies and Surveillance of Disease Problems" and may be disclosed; to appropriate State or local public health departments and cooperating medical authorities to deal with conditions of public health significance; to private contractors assisting CDC in analyzing and relaying records; to researchers under certain limited circumstances - to conduct further investigations; to organizations to carry out studies and reviews on behalf of HHS; to the Department of Justice in the event of litigation; and to a congressional office assisting individuals in obtaining their records. An accounting of the disclosure that have been made by CDC will be made available to the subject individual upon request. Except for permissible disclosures expressly authorized by the Privacy Act, no other disclosure may be made without the subject individual's written consent. Public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to PHS Reports Clearance Officer, ATTN: PRA, Herbert H. Humphrey Bldg., Rm. 721-B, 200 Independence Ave., SW, Washington, DC 20201, and to the Office of Management and Budget, Paperwork Reduction Project (0920-0009), Washington, D.C. 20503.

18. Did the patient have a recent viral or bacterial infection (associated with Reye Syndrome) documented by culture, serology or other laboratory test?

				IF YES, HOW WAS AGENT IDENTIFIED			
	Yes	No	Unknown	Culture	Serology	Other	Unknown
Flu A	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9 (88)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9 (89)
Flu B	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9 (90)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9 (91)
Other (specify)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9 (92)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9 (93)

19. Was there a three-fold or greater elevation in the normal laboratory value of either the serum SGOT, SGPT or NH_3 ? (94) ☐ 1 Yes ☐ 0 No ☐ 9 Unknown

20. What were the patient's highest lab values for the following:

SGOT	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Units	SGPT	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Units	NH_3	<input type="text"/>	<input type="text"/>	<input type="text"/>	$\mu\text{g}/100\text{ml}$
	(95-98)						(99-102)					(103-106)				

21. What was the lowest serum glucose value? mg% (107-110)

22. What were the patient's highest lab values for the following:

CPK	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Units	BLANK
	(111-114)					(115-116)

23. Was patient's cerebrospinal (CSF) cell count normal? (117) ☐ 1 Yes ☐ 0 No ☐ 3 Not done

Enter the following in spaces provided:

TOTAL WBC	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	mm^3	RBC	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	mm^3	%LYMPH	<input type="text"/>	<input type="text"/>	%POLY	<input type="text"/>	<input type="text"/>	PROT	<input type="text"/>	<input type="text"/>	mg%	GLUCOSE	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg%
	(118-121)						(122-125)					(126-127)			(128-129)			(130-131)			(132-134)					

24. Was blood for a salicylate level obtained within 48 hours of admission to the hospital? (135) ☐ 1 Yes ☐ 0 No ☐ 9 Unknown

If YES, was salicylate detectable? (136) ☐ 1 Yes ☐ 0 No ☐ 9 Unknown

BLANK
(139)-(162)

If YES, how many mg %? (137-138)

25. What was outcome of this illness? Select the most appropriate answer. (163)

- ☐ 1. Prognosis unclear at present
- ☐ 2. Patient recovered
- ☐ 3. Suffered mild neurological residual
- ☐ 4. Suffered severe neurological residual
- ☐ 5. Patient died
- ☐ 6. Outcome unknown

26. Is there biopsy confirmation of the diagnosis? (check only one) (164)

- ☐ 1 Yes
- ☐ 0 No
- ☐ 3 Biopsy not done
- ☐ 9 Unknown

27. IF APPLICABLE, is there autopsy confirmation of the diagnosis? (165)

- ☐ 1 Yes, autopsy confirmed diagnosis of Reye Syndrome.
- ☐ 0 No, autopsy was done but did not confirm diagnosis of Reye Syndrome
- ☐ 3 Autopsy not done
- ☐ 9 Unknown

28. ENTER DATA REPORT TAKEN

Mo.	<input type="text"/>	Day	<input type="text"/>	Yr.	<input type="text"/>	BILIRUBIN	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg/100ml
	(166-171)					(total)	(172-174)			

29. Is the patient one of identical twins? (175)

- ☐ 1 Yes
- ☐ 0 No
- ☐ 9 Unknown

30. Was blood for an acetaminophen level obtained within 48 hours of admission to the hospital? (176)

- ☐ 1 Yes
- ☐ 0 No
- ☐ 9 Unknown

If YES, was acetaminophen detectable? (177)

- ☐ 1 Yes
- ☐ 0 No
- ☐ 9 Unknown

If YES, how many $\mu\text{g}/\text{ml}$ (178-179)

QUESTION 30 (A, B, C & D) OPTIONAL

31. A. Did the patient take any medications (nonprescription or prescribed) during the 3 weeks prior to the onset of Reye Syndrome (defined as vomiting or mental status changes)? (180)

- ☐ 1 Yes
- ☐ 0 No
- ☐ 9 Unknown

B. Please list all of these medications below (include brand names if possible): (181-186)

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

C. How did you obtain this medication history?

1. Chart review ☐ (187)
2. Interviewed patient's physician ☐ (188)
3. Interviewed patient's parent ☐ (189)
4. Other (specify) _____ ☐ (190)

D. If obtained only by chart review, which did the medication history specifically indicate? (check all that apply)

1. Patient took acetaminophen during the three weeks ☐ (191)
2. Patient did not take acetaminophen during the three weeks ☐ (192)
3. No information regarding acetaminophen ingestion ☐ (193)
4. Patient took salicylate during the three weeks ☐ (194)
5. Patient did not take salicylate during the three weeks ☐ (195)
6. No information regarding salicylate ingestion ☐ (196)

32. A. Does the patient have a disease which requires the patient to take salicylate-containing medications regularly?

- (197) ☐ 1 Yes
- ☐ 0 No
- ☐ 9 Unknown

B. If YES, what is the disease?

1. Juvenile Rheumatoid Arthritis ☐
2. Other (specify): _____ ☐ (198)

RETURN TO: Centers for Disease Control
ATTN: Reye Syndrome Unit
Building 6, Room 125
Atlanta, Georgia 30333

PLEASE CHECK OVER ALL ANSWERS TO MAKE SURE THEY CAN BE READ AND PROCESSED APPROPRIATELY FOR DATA COLLECTION.